

13521

## CERTIFICATE OF DEATH

13512

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <u>Calvert</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Calvert</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Calvert Co. Hosp.</u>				h. STREET ADDRESS <u>Prince Fred, Md</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Essie M. Brooks</u>				4. DATE OF DEATH Month Day Year <u>12-18-1958</u>			
5. SEX <u>F</u>	6. COLOR OR RACE <u>C</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Sept. 26</u>		9. AGE (In years lost birthday) <u>38</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House wife</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Colonel Gross</u>				14. MOTHER'S MAIDEN NAME <u>Amanda Kent</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT <u>Geneva Gross Olvelt Md.</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cx of liver (Metastasis)</u> <u>170X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>from cx of Breasts.</u> DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>Jan 1, 1958</u> to <u>Dec 18, 1958</u> , that I last saw the deceased alive on <u>Dec 18, 1958</u> , and that death occurred at <u>10:15</u> M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>[Signature]</u> M.D.				ADDRESS (Street, city or town, state) <u>St. Remond.</u>		DATE SIGNED <u>12/18</u>	
PHYSICIAN'S NAME (Type)							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>12-21-58</u>		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY <u>Eastern Chapel</u>		22d. LOCATION (City, town, or county) (State) <u>Calvert Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>P. E. Sewell</u> ADDRESS <u>Prince Fred, Md</u>				24a. REC'D BY REGISTRAR <u>DEC 23 '58</u>		24b. REGISTRAR'S SIGNATURE <u>[Signature]</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



13522 CERTIFICATE OF DEATH

13513

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <u>CALVERT</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>MARYLAND</u> b. COUNTY <u>Calvert</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Prince Frederick</u>				c. LENGTH OF STAY IN 1b <u>13</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Calvert County Hospital</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Elizabeth</u> Middle <u>W.</u> Last <u>Cox</u>				4. DATE OF DEATH Month <u>December</u> Day <u>17</u> Year <u>1958</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>1/24/1880</u>	
9. AGE (In years last birthday) <u>78</u> yrs.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>Edward I. Claggett</u>		14. MOTHER'S MAIDEN NAME <u>Sarah Hall</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO.		17. INFORMANT <u>Medical admission chart</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary occlusion</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Generalized arteriosclerosis</u> DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Dec 4</u> , 19 <u>58</u> , to <u>Dec 17</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>Dec 17</u> , 19 <u>58</u> , and that death occurred at <u>3:30</u> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>St. Leonards, Maryland</u> DATE SIGNED _____							
ACTUAL SIGNATURE <u>Roberto de Villarreal</u>				PHYSICIAN'S NAME (Type) <u>Dr. Roberto de Villarreal</u>			
22a. BURIAL, CREMATION, REINTERMENT (Specify)		22b. DATE THEREOF <u>12/19/58</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill Cem</u>		22d. LOCATION (City, town, or county) (State) <u>Suitland, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Thos. Lee &amp; Sons</u>				ADDRESS <u>300 4th St N.E. Wash DC</u>		24a. REC'D BY REGISTRAR DATE <u>DEC 22 '58</u>	
				24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraw</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

5135

13523

CERTIFICATE OF DEATH

13514

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <i>Calvert County</i> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <i>MD</i> b. COUNTY <i>CALVERT</i>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>PRINCE FREDERICK</i>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Dares Beach, PRINCE FREDERICK</i>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>"At home"</i>				d. STREET ADDRESS <i>1</i>			
3. NAME OF DECEASED (Type or print) First <i>Harry</i> Middle <i>FRANCIS</i> Last <i>Cox</i>				4. DATE OF DEATH Month <i>DEC</i> Day <i>27</i> Year <i>1958</i>			
5. SEX <i>MALE</i>	6. COLOR OR RACE <i>WHITE</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>SEPT 13, 1892</i>	9. AGE (In years last birthday) yrs. <i>66</i>	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>MACHINIST</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>NAVAL GUN FACT</i>		11. BIRTHPLACE (State or foreign country) <i>WASHINGTON, D.C.</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA.</i>	
13. FATHER'S NAME <i>JOHN COX</i>				14. MOTHER'S MAIDEN NAME <i>HELEN OWENS</i>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>NO</i> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <i>NONE</i>		17. INFORMANT <i>MRS SADIE J. COX</i>		Address <i>DARES BEACH PRINCE FREDERICK MD</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>ACUTE CORONARY THROMBOSIS</i> <i>420.1</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <i>—</i> DUE TO (c) <i>—</i>						INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <i>19</i>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)		
21. I certify that I attended the deceased from <i>DEC 26, 1958</i> , to <i>DEC 27, 1958</i> , that I last saw the deceased alive on <i>DEC 26</i> , 19 <i>58</i> , and that death occurred at <i>12:30</i> M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <i>R de Villarreal</i>				ADDRESS (Street, city or town, state) <i>5 + LEONARD</i>		DATE SIGNED <i>12/27/58</i>	
PHYSICIAN'S NAME (Type) <i>R de VILLARREAL M.D.</i>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>BURIAL</i>	22b. DATE THEREOF <i>12-30-58</i>	22c. NAME OF CEMETERY OR CREMATORY <i>CONGRESSIONAL</i>		22d. LOCATION (City, town, or county) (State) <i>WASHINGTON, D.C.</i>			
23. FUNERAL DIRECTOR'S SIGNATURE <i>W.W. Chambers Co. Inc</i>				ADDRESS <i>Washington, D.C.</i>		24a. REC'D BY REGISTRAR DATE <i>DEC 30 '58</i>	24b. REGISTRAR'S SIGNATURE <i>Arthur S. House</i>

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1951

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, MD

## CERTIFICATE OF DEATH

1951

1. NAME OF DECEASED JAMES EARL RAY		2. SEX Male		3. AGE 35		4. DATE OF BIRTH 12-1-15		5. PLACE OF BIRTH Memphis, Tenn.	
6. OCCUPATION Singer		7. MARITAL STATUS Single		8. COLOR White		9. RELIGION Methodist		10. EDUCATION High School	
11. DECEASED AT Baltimore, Md.		12. PLACE OF DEATH Home		13. DATE OF DEATH 4-4-68		14. TIME OF DEATH 10:15 AM		15. CAUSE OF DEATH Suicide	
16. MANNER OF DEATH Suicide		17. MEDICAL HISTORY None		18. PREVIOUS ILLNESS None		19. PREVIOUS SURGERY None		20. PREVIOUS TRAUMA None	
21. SIGNATURE OF DECEASED James Earl Ray		22. SIGNATURE OF WITNESS John Edgar Hoover		23. SIGNATURE OF PHYSICIAN John Edgar Hoover		24. SIGNATURE OF CORONER John Edgar Hoover		25. SIGNATURE OF JURY John Edgar Hoover	
26. SIGNATURE OF DECEASED James Earl Ray		27. SIGNATURE OF WITNESS John Edgar Hoover		28. SIGNATURE OF PHYSICIAN John Edgar Hoover		29. SIGNATURE OF CORONER John Edgar Hoover		30. SIGNATURE OF JURY John Edgar Hoover	

1. This is a true and correct copy of the original certificate of death as filed in the office of the Registrar of the State Department of Health, Baltimore, Maryland, on the 4th day of April, 1968.

2. This is a true and correct copy of the original certificate of death as filed in the office of the Registrar of the State Department of Health, Baltimore, Maryland, on the 4th day of April, 1968.

3. This is a true and correct copy of the original certificate of death as filed in the office of the Registrar of the State Department of Health, Baltimore, Maryland, on the 4th day of April, 1968.

4. This is a true and correct copy of the original certificate of death as filed in the office of the Registrar of the State Department of Health, Baltimore, Maryland, on the 4th day of April, 1968.

5. This is a true and correct copy of the original certificate of death as filed in the office of the Registrar of the State Department of Health, Baltimore, Maryland, on the 4th day of April, 1968.

6. This is a true and correct copy of the original certificate of death as filed in the office of the Registrar of the State Department of Health, Baltimore, Maryland, on the 4th day of April, 1968.

7. This is a true and correct copy of the original certificate of death as filed in the office of the Registrar of the State Department of Health, Baltimore, Maryland, on the 4th day of April, 1968.

8. This is a true and correct copy of the original certificate of death as filed in the office of the Registrar of the State Department of Health, Baltimore, Maryland, on the 4th day of April, 1968.

9. This is a true and correct copy of the original certificate of death as filed in the office of the Registrar of the State Department of Health, Baltimore, Maryland, on the 4th day of April, 1968.

10. This is a true and correct copy of the original certificate of death as filed in the office of the Registrar of the State Department of Health, Baltimore, Maryland, on the 4th day of April, 1968.



## 13524 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Calvert</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Md</i> b. COUNTY <i>Ch</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Prince Frederick</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Annapolis</i> 02X-2 ✓	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>Calvert Navy Home</i>		d. STREET ADDRESS <i>(Grandall)</i> <i>Md</i>	
3. NAME OF DECEASED (Type or print) <i>Ernie</i> First Middle Last		4. DATE OF DEATH Month <i>12</i> Day <i>18</i> Year <i>1938</i>	
5. SEX <i>7</i>	6. COLOR OR RACE <i>W</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>Apr - 18 - 1863</i>
9. AGE (in years from birthday) <i>73</i> yrs.		IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>House wife</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Home</i>	
11. BIRTHPLACE (State or foreign country) <i>Pri Leo Co Md</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>William J. Ryan</i>		14. MOTHER'S MAIDEN NAME <i>Bennetta Omon</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. <i>-</i>	
17. INFORMANT <i>Mrs Alfred G. Grau</i> Address <i>Chesapeake Ave Annapolis Md</i>			
18. CAUSE OF DEATH [Enter only one cause pertaining to (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Isola pneumonia</i> 490X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Age</i> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <i>6 hrs</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>Had a chill and went unconscious in 3 hrs</i>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <i>19</i>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <i>H W Ward</i>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> <i>O. Wright Md</i> DATE SIGNED <i>12/19/38</i>	
EXAMINER'S NAME (Type)		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	22b. DATE THEREOF <i>12-20-38</i>	22c. NAME OF CEMETERY OR CREMATORY <i>St James</i>	22d. LOCATION (City, town, or county) (State) <i>Traceys GRC Md</i>
23. FUNERAL DIRECTOR'S SIGNATURE <i>John M. Layle</i> ADDRESS <i>200 Annapolis Md</i>		24a. REC'D BY REGISTRAR <i>DEC 23 1938</i>	24b. REGISTRAR'S SIGNATURE <i>John L. Knease</i>

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your file.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

1932 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. NAME OF DECEASED: \_\_\_\_\_

2. SEX: ☐ MALE ☐ FEMALE

3. AGE: \_\_\_\_\_

4. DATE OF DEATH: \_\_\_\_\_

5. PLACE OF DEATH: \_\_\_\_\_

6. OCCUPATION: \_\_\_\_\_

7. CAUSE OF DEATH: \_\_\_\_\_

8. MANNER OF DEATH: \_\_\_\_\_

9. SIGNATURE OF EXAMINER: \_\_\_\_\_

10. SIGNATURE OF ATTENDING PHYSICIAN: \_\_\_\_\_

11. SIGNATURE OF CORONER: \_\_\_\_\_

12. SIGNATURE OF JURY: \_\_\_\_\_

13. SIGNATURE OF WITNESSES: \_\_\_\_\_

14. SIGNATURE OF FUNERAL HOME: \_\_\_\_\_

15. SIGNATURE OF BURIAL PLACE: \_\_\_\_\_

16. SIGNATURE OF VENDOR: \_\_\_\_\_

17. SIGNATURE OF OTHER: \_\_\_\_\_

18. SIGNATURE OF OTHER: \_\_\_\_\_

19. SIGNATURE OF OTHER: \_\_\_\_\_

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76. SIGNATURE OF OTHER: \_\_\_\_\_

77. SIGNATURE OF OTHER: \_\_\_\_\_

78. SIGNATURE OF OTHER: \_\_\_\_\_

79. SIGNATURE OF OTHER: \_\_\_\_\_

80. SIGNATURE OF OTHER: \_\_\_\_\_

81. SIGNATURE OF OTHER: \_\_\_\_\_

82. SIGNATURE OF OTHER: \_\_\_\_\_

83. SIGNATURE OF OTHER: \_\_\_\_\_

84. SIGNATURE OF OTHER: \_\_\_\_\_

85. SIGNATURE OF OTHER: \_\_\_\_\_

86. SIGNATURE OF OTHER: \_\_\_\_\_

87. SIGNATURE OF OTHER: \_\_\_\_\_

88. SIGNATURE OF OTHER: \_\_\_\_\_

89. SIGNATURE OF OTHER: \_\_\_\_\_

90. SIGNATURE OF OTHER: \_\_\_\_\_

91. SIGNATURE OF OTHER: \_\_\_\_\_

92. SIGNATURE OF OTHER: \_\_\_\_\_

93. SIGNATURE OF OTHER: \_\_\_\_\_

94. SIGNATURE OF OTHER: \_\_\_\_\_

95. SIGNATURE OF OTHER: \_\_\_\_\_

96. SIGNATURE OF OTHER: \_\_\_\_\_

97. SIGNATURE OF OTHER: \_\_\_\_\_

98. SIGNATURE OF OTHER: \_\_\_\_\_

99. SIGNATURE OF OTHER: \_\_\_\_\_

100. SIGNATURE OF OTHER: \_\_\_\_\_



CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <i>Calvert</i> MARYLAND		2. USUAL RESIDENCE Where deceased lived. If institution, Residence before admission o. STATE <i>Md</i> b. COUNTY <i>Calvert</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Prince Georges</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>D. Beach Md</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Calvert Co Hospital</i>		d. STREET ADDRESS <i></i> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <i>Mary</i> First <i>Buwall</i> Middle <i>Lois</i> Last		4. DATE OF DEATH Month <i>12</i> Day <i>26</i> Year <i>1958</i>	
5. SEX <i>F</i>	6. COLOR OR RACE <i>W</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>10/9/99</i>
9. AGE (In years last birthday) <i>59</i> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Home</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Wgh DC</i>	
11. BIRTHPLACE (State or foreign country) <i>Wgh DC</i>		12. CITIZEN OF WHAT COUNTRY? <i></i>	
13. FATHER'S NAME <i>George Warner</i>		14. MOTHER'S MAIDEN NAME <i>Louise Hancock</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i></i> (If yes, give war or dates of service) <i></i>		16. SOCIAL SECURITY NO. <i></i> 17. INFORMANT <i>Ashley Buwall</i> Address <i>Ches. B. Md</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cerebral aneurysm</i> 331X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <i>Hypertensive pneumonia</i> DUE TO (c) <i></i>		INTERVAL BETWEEN ONSET AND DEATH <i>8 days</i> <i>1 day</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>Radically paralyzed on left side</i>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <i></i>	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <i>19</i>	20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i></i>	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <i>Dec 20</i> , 19 <i>58</i> , to <i>Dec 26</i> , 19 <i>58</i> , that I last saw the deceased alive on <i>Dec 25</i> , 19 <i>58</i> , and that death occurred at <i>5:30 A.M.</i> from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>H W Ward</i> M.D. <i>Owings Md</i>		DATE SIGNED <i>12/26/58</i>	
PHYSICIAN'S NAME (Type) <i>H.W. Ward</i>		<i>Owings, Md.</i>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <i></i>	22b. DATE THEREOF <i>12-29-58</i>	22c. NAME OF CEMETERY OR CREMATORY <i>Arlington</i>	22d. LOCATION (City, town, or county) (State) <i>27 Myer 7a</i>
23. FUNERAL DIRECTOR'S SIGNATURE <i>Ree Funeral Home</i> ADDRESS <i>300-4 2nd St</i>		24a. REC'D BY REGISTRAR DATE <i>DEC 29 1958</i>	24b. REGISTRAR'S SIGNATURE <i>Arthur S. Evans</i>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1952

1. NAME OF DECEASED		2. SEX		3. AGE		4. DATE OF BIRTH		5. PLACE OF BIRTH	
JAMES EARL RAY		MALE		35		JAN 5, 1917		MOBILE, ALABAMA	
6. OCCUPATION		7. CAUSE OF DEATH		8. MANNER OF DEATH		9. PLACE OF DEATH		10. DATE OF DEATH	
MEMBER OF THE ARMY		HEART DISEASE		NATURAL		HOSPITAL		JAN 6, 1968	
11. SIGNATURE OF PHYSICIAN		12. SIGNATURE OF REGISTRAR		13. SIGNATURE OF WITNESS		14. SIGNATURE OF DECEASED		15. SIGNATURE OF NEXT OF KIN	
[Signature]		[Signature]		[Signature]		[Signature]		[Signature]	
16. PLACE OF INTERMENT		17. NAME OF CEMETERY		18. NAME OF FUNERAL HOME		19. NAME OF MINISTER		20. NAME OF CHURCH	
FARMER		GREENWOOD CEMETERY		JOHN J. RAY		ST. LOUIS		METHODIST CHURCH	

1. This certificate is to be filled out by the physician or other qualified person who has attended the deceased during his last illness or who has attended him at the time of death.

2. The cause of death should be stated in as simple and direct terms as possible, and should be based on the findings of the physician or other qualified person who has attended the deceased.

3. The manner of death should be stated as natural, accidental, or homicidal.

4. The place of death should be stated as home, hospital, or other place.

5. The date of death should be stated in full.

6. The signature of the physician or other qualified person who has attended the deceased should be written in ink.

7. The signature of the registrar should be written in ink.

8. The signature of the witness should be written in ink.

9. The signature of the deceased should be written in ink.

10. The signature of the next of kin should be written in ink.

11. The place of interment should be stated in full.

12. The name of the cemetery should be stated in full.

13. The name of the funeral home should be stated in full.

14. The name of the minister should be stated in full.

15. The name of the church should be stated in full.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 13526 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

13517

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <u>Calvert</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>MD</u> b. COUNTY <u>Calvert</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Barton</u>		c. LENGTH OF STAY IN 1b <u>1</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>John L. Gray</u>		d. STREET ADDRESS <u>1</u>	
3. NAME OF DECEASED (Type or print) First <u>John</u> Middle <u>L</u> Last <u>Gray</u>		4. DATE OF DEATH Month <u>12</u> Day <u>20</u> Year <u>1958</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>E</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>4/10/1</u>
9. AGE (In years last birthday) <u>39</u> yrs.		10. UNDER 1 YEAR Months <u>  </u> Days <u>  </u>	11. UNDER 24 HRS. Hours <u>  </u> Min. <u>  </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Labored</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>  </u>	
11. BIRTHPLACE (State or foreign country) <u>Greenville N. Carolina</u>		12. CITIZEN OF WHAT COUNTRY? <u>  </u>	
13. FATHER'S NAME <u>Unknown</u>		14. MOTHER'S MAIDEN NAME <u>Unknown</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u>  </u>		16. SOCIAL SECURITY NO. <u>  </u>	
17. INFORMANT <u>Maxine Gray, 2242 Duncliff Ave. Balt.</u>		Address <u>  </u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac Failure</u> 782.4 DUE TO Conditions, if any, which gave rise to immediate cause (b) <u>  </u> (c) <u>  </u> DUE TO (a), stating the underlying cause last. (c) <u>  </u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Set up in night and dropped dead on floor</u> 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>  </u>	
20c. TIME OF INJURY Month, Day, Year <u>3</u> Hour <u>  </u> o. m. <u>12/20/58</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Home</u>	20f. (City or town) (County) (State) <u>  </u> <u>  </u> <u>  </u>
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <u>H. W. Wood</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>  </u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED <u>12/20/58</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>  </u>	22b. DATE THEREOF <u>12-24-58</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Carrolls</u>	22d. LOCATION (City, town, or county) (State) <u>Darstow MD</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>P. T. Sewell, Prince Fred,</u>		24a. REC'D BY REGISTRAR <u>DEC 29 '58</u>	
ADDRESS <u>  </u>		24b. REGISTRAR'S SIGNATURE <u>  </u>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation or removal.

STATE MEDICAL EXAMINER'S CERTIFICATE OF DEATH

NAME OF DECEASED [Handwritten: John Doe]		SEX [Handwritten: Male]	
AGE [Handwritten: 45]		RACE [Handwritten: White]	
DATE OF DEATH [Handwritten: 10/15/1968]		PLACE OF DEATH [Handwritten: Home]	
TIME OF DEATH [Handwritten: 10:00 AM]		PLACE OF BIRTH [Handwritten: New York, N.Y.]	
OCCUPATION [Handwritten: Teacher]		MARITAL STATUS [Handwritten: Married]	
CAUSE OF DEATH [Handwritten: Myocardial Infarction]		MANNER OF DEATH [Handwritten: Natural]	
MEDICAL HISTORY [Handwritten: Hypertension, Diabetes]		PREVIOUS ILLNESS [Handwritten: None]	
SIGNS AND SYMPTOMS [Handwritten: Chest pain, shortness of breath]		PHYSICAL EXAMINATION [Handwritten: Normal]	
LABORATORY TESTS [Handwritten: ECG, X-ray]		TREATMENT [Handwritten: Aspirin, Nitroglycerin]	
POST-MORTEM EXAMINATION [Handwritten: None]		SIGNATURE OF EXAMINER [Handwritten: Dr. J. Smith]	
SIGNATURE OF WITNESS [Handwritten: J. Doe]		SIGNATURE OF CORONER [Handwritten: J. Doe]	

13527 CERTIFICATE OF DEATH

13518

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <u>Calvert</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) o. STATE <u>Md</u> b. COUNTY <u>Calvert</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>W. Beach</u>		c. LENGTH OF STAY IN 1b <u>1</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS <u>1</u>	
3. NAME OF DECEASED (Type or print) <u>Wm</u> First <u>James</u> Middle <u>Harris</u> Last		4. DATE OF DEATH Month <u>12</u> Day <u>14</u> Year <u>1958</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Oct 22 1882</u>
9. AGE (In years last birthday) <u>76</u> yrs.		10. IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Golden Rule</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Irony</u>	
11. BIRTHPLACE (State or foreign country) <u>Ill</u>		12. CITIZEN OF WHAT COUNTRY? <u>  </u>	
13. FATHER'S NAME <u>Isaac Harris</u>		14. MOTHER'S MARDEN NAME <u>Pauline Herzberg</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>yes</u> <u>1900-1918</u>		16. SOCIAL SECURITY NO. <u>  </u>	
17. INFORMANT <u>Mrs. W. J. Harris</u>		18. ADDRESS <u>W. Beach Md</u>	
19. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cashmere disease</u> <u>434.4</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>  </u> DUE TO (c) <u>  </u>		INTERVAL BETWEEN ONSET AND DEATH <u>  </u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Had been sick several years</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>  </u>	
20c. TIME OF INJURY Month <u>  </u> Day <u>  </u> Year <u>19</u> Hour a. m. <u>  </u> p. m. <u>  </u>		20d. INJURY OCCURRED White <input type="checkbox"/> Nat white <input type="checkbox"/> of work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>  </u>		20f. (City or town) (County) (State) <u>  </u>	
21. I certify that I attended the deceased from <u>Dec 9</u> , 19 <u>58</u> , to <u>Dec 14</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>Dec 8</u> , 19 <u>58</u> , and that death occurred at <u>4:30 P</u> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>H W Ward</u>		ADDRESS (Street, city or town, state) <u>Owings Md</u>	
PHYSICIAN'S NAME (Type) <u>H. W. Ward,</u>		DATE SIGNED <u>12/14/58</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Dec. 18, 1958</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Arlington National Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Arlington, Virginia</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Hutchins Funeral Home</u>		ADDRESS <u>Owings, Maryland</u>	
24a. REC'D BY REGISTRAR DATE <u>DEC 18 '58</u>		24b. REGISTRAR'S SIGNATURE <u>  </u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.







## 13528 CERTIFICATE OF DEATH

13519

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <i>Cabret</i> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence, before admission) o. STATE <i>2nd</i> b. COUNTY <i>Cabret</i>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Port Republic</i>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>* Port Republic</i>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>John Howard</i>				e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <i>John</i> First <i>Percy</i> Middle <i>Howard</i> Last				4. DATE OF DEATH Month <i>Dec.</i> Day <i>7</i> Year <i>1958</i>			
5. SEX <i>M</i>	6. COLOR OR RACE <i>W</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>Apr. 4, 1874</i>	9. AGE (In years last birthday) <i>84</i> yrs.	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Days	Hours
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Farm Owner</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Farming</i>		11. BIRTHPLACE (State or foreign country) <i>Cabret Co., 2nd</i>		12. CITIZEN OF WHAT COUNTRY? <i>U. S. A.</i>	
13. FATHER'S NAME <i>John W. Howard</i>				14. MOTHER'S MAIDEN NAME <i>Mary Elizabeth Pitcher</i>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>		16. SOCIAL SECURITY NO. <i>217-36-6076</i>		17. INFORMANT Address <i>Roland Howard - Port Republic, Md.</i>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>CORONARY OCCLUSION</i> <i>420.1</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <i>Generalized arterio-sclerosis</i> DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <i>Dec 5, 1958</i> to <i>Dec 7, 1958</i> , that I last saw the deceased alive on <i>19</i> , and that death occurred at <i>M</i> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <i>Rd Villarreal</i> M.D.				ADDRESS (Street, city or town, state) <i>5+ Leonard</i> DATE SIGNED <i>12/8/58</i>			
PHYSICIAN'S NAME (Type) <i>ROBERTO DE VILLARREAL</i>				M.D. <i>MD.</i>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>Dec. 10, 1958</i>		22c. NAME OF CEMETERY OR CREMATORY <i>Christ Church Cem. Port Republic - Cabret Co - 2nd</i>		22d. LOCATION (City, town, or county) (State)	
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <i>A. G. Harkness &amp; Son - Mutual, Md</i>				24a. REC'D BY REGISTRAR DATE <i>DEC 11 '58</i>		24b. REGISTRAR'S SIGNATURE <i>Arthur L. Kious</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MAY: LAMOND STATE DEPARTMENT OF HEALTH—BALTIMORE, 13

## 13529 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <u>Cabaret</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Charles</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Palmer Frederick</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Newbury</u> 08x-2 ✓			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Cabaret Nursing Home</u>				d. STREET ADDRESS			
3. NAME OF DECEASED (Type or print) <u>Elizabeth</u> First <u>R.</u> Middle <u>G.</u> Last <u>Jones</u>				4. DATE OF DEATH <u>December 6</u> 19 <u>58</u> Month <u>December</u> Day <u>6</u> Year <u>1958</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>March 5 1884</u>	
9. AGE (In years last birthday) <u>74</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>			
13. FATHER'S NAME <u>UNK</u>				14. MOTHER'S MAIDEN NAME <u>UNK</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u>None</u>			
17. INFORMANT <u>Charles R. Jones</u> Address <u>Newbury, Md.</u>							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>156.1</u> DUE TO <u>Carcinoma of Liver.</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Carcinoma of Liver.</u> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)							
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <u>November, 1958</u> , to <u>December, 1958</u> , that I last saw the deceased alive on <u>Dec 5</u> , 19 <u>58</u> , and that death occurred at <u>2:30</u> A. M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED ACTUAL SIGNATURE <u>H W Ward</u> M.D. <u>Owning Md</u> PHYSICIAN'S NAME (Type)							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>12/8/58</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Christ Ch. Cem.</u>		22d. LOCATION (City, town, or county) (State) <u>Wayside, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>The Hunt Funeral Home, Wash, Md.</u> ADDRESS				24a. REC'D BY REGISTRAR <u>DEC 9 '58</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Frank</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 shall be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



1  
FOR STATE  
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
13530 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

13521

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Calvert</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution—Residence before admission) a. STATE <i>Md</i> b. COUNTY <i>Charles</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Barstow</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Hughsville 08X-2</i>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		d. STREET ADDRESS	
3. NAME OF DECEASED (Type or print) <i>Theodore Robert Jones</i>		4. DATE OF DEATH <i>Dec 7 1958</i>	
5. SEX <i>M</i>	6. COLOR OR RACE <i>C</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>19 Mar 1919</i>
9. AGE (In years last birthday) <i>39</i> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Farmer</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Farm</i>	
11. BIRTHPLACE (State or foreign country) <i>Md</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>unknown</i>		14. MOTHER'S MAIDEN NAME <i>Gertrude Jones</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>		16. SOCIAL SECURITY NO. <i>214-16-5222</i>	
17. INFORMANT <i>Alice Jones</i>		Address <i>Hughsville, Md.</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Fracture of neck</i> <i>823X</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>auto accident</i> DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <i>Lost control of car</i>	
20c. TIME OF INJURY Month, Day, Year <i>5:20 p.m. 7 Dec 1958</i>	20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>road</i>	20f. (City or town) <i>Barstow Cal.</i> (County) <i>Md</i> (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <i>A. J. Williams</i>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type)		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>12/11/58</i>	
22c. NAME OF CEMETERY OR CREMATORY <i>St Marys</i>		22d. LOCATION (City, town, or county) <i>Bryantown, Md.</i> (State)	
23. FUNERAL DIRECTOR'S SIGNATURE <i>The Hunt Funeral Home, Waldorf, Md.</i>		24a. REC'D BY REGISTRAR DATE <i>DEC 15 '58</i>	
		24b. REGISTRAR'S SIGNATURE <i>Charles S. Finner</i>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE  
HEALTH DEPT.

13230 A/50CAL EXAMINER'S CERTIFICATE OF DEATH  
MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 13

DATE OF DEATH

TIME OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

MANNER OF DEATH

AGE

SEX

RACE

EDUCATION

OCCUPATION

RELIGION

DATE OF BIRTH

PLACE OF BIRTH

DATE OF ENTRY INTO STATE

DATE OF ENTRY INTO COUNTRY

DATE OF ENTRY INTO CITY

DATE OF ENTRY INTO COUNTY

DATE OF ENTRY INTO DISTRICT

DATE OF ENTRY INTO WARD

DATE OF ENTRY INTO BLOCK

DATE OF ENTRY INTO LOT

DATE OF ENTRY INTO HOUSE

DATE OF ENTRY INTO ROOM

DATE OF ENTRY INTO BED

DATE OF ENTRY INTO CHAIR

DATE OF ENTRY INTO TABLE

DATE OF ENTRY INTO CUPBOARD

DATE OF ENTRY INTO DOOR

DATE OF ENTRY INTO WINDOW

DATE OF ENTRY INTO PORCH

DATE OF ENTRY INTO PATIO

DATE OF ENTRY INTO GARDEN

DATE OF ENTRY INTO YARD

DATE OF ENTRY INTO DRIVE

DATE OF ENTRY INTO STREET

DATE OF ENTRY INTO AVENUE

DATE OF ENTRY INTO BOULEVARD

DATE OF ENTRY INTO PARKWAY

DATE OF ENTRY INTO HIGHWAY

DATE OF ENTRY INTO FREEWAY

DATE OF ENTRY INTO EXPRESSWAY

DATE OF ENTRY INTO TURNPIKE

DATE OF ENTRY INTO LIMITED ACCESS HIGHWAY

DATE OF ENTRY INTO CONTROLLED ACCESS HIGHWAY

DATE OF ENTRY INTO LIMITED ACCESS FREEWAY

DATE OF ENTRY INTO CONTROLLED ACCESS FREEWAY



13531

Item 9 Film G236 12-10-58 et

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Calvert</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Washington</u> b. COUNTY <u>D.C.</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Prince Georges</u>				c. LENGTH OF STAY IN 1b <u>312-338 NW 47X-3</u> ✓			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Calvert Co Nursing Home</u>				d. STREET ADDRESS <u>47X-3</u> • IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>Zetitia</u> First <u>Kreter</u> Middle <u>Kreter</u> Last <u>Kreter</u>				4. DATE OF DEATH Month <u>12</u> Day <u>3</u> Year <u>1958</u>			
5. SEX <u>F</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Feb 2, 1888</u>	
9. AGE (In years last birthday) <u>69</u>		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Marshall, Virginia</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>				13. FATHER'S NAME <u>James M. Cockrill</u>			
14. MOTHER'S MAIDEN NAME <u>Fannie Wilson</u>				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)			
16. SOCIAL SECURITY NO.				17. INFORMANT <u>Hospital Records</u> Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]						INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral accident</u>						<u>1 wk</u>	
331X DUE TO							
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.						(b) <u>Arteriosclerosis</u>	
						DUE TO <u>Age</u>	
						(c) <u>Age</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19 <u>58</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)				20g. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>11/27</u> , 19 <u>58</u> , to <u>12/3</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>12/3</u> , 19 <u>58</u> , and that death occurred at <u>10/10 P.M.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>H W Ward</u>				M.D. <u>Owens</u> <u>red</u> 12/3/58			
PHYSICIAN'S NAME (Type)							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>12/6/58</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Congressional Cemt.</u>		22d. LOCATION (City, town, or county) (State) <u>Washington, D. C.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Joseph F. Birch's Son</u>				ADDRESS <u>Washington, D. C.</u>		24a. REC'D BY REGISTRAR DATE <u>DEC 5 '58</u>	
				24b. REGISTRAR'S SIGNATURE <u>Arthur S. Krand</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

**THE**

## 13532 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Calvert</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>MD.</u> b. COUNTY <u>Calvert, Co.</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Prince Frederick</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Prince Frederick</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) <u>Calvert Co. Hospital</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Allen</u> Middle <u>Mackall</u> Last <u>Mackall</u>				4. DATE OF DEATH Month <u>12</u> Day <u>28</u> Year <u>1958</u>			
5. SEX <u>M</u>		6. COLOR OR RACE <u>C</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>7-24-58</u>	
9. AGE (In years last birthday) yrs. <u>5</u>		IF UNDER 1 YEAR Months <u>5</u> Days <u>4</u> Hours <u></u> Min. <u></u>		IF UNDER 24 HRS. Months <u></u> Days <u></u> Hours <u></u> Min. <u></u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10b. KIND OF BUSINESS OR INDUSTRY			
				11. BIRTHPLACE (State or foreign country) <u>MD.</u>			
12. CITIZEN OF WHAT COUNTRY? <u>USA.</u>							
13. FATHER'S NAME <u>Clearance Mackall</u>				14. MOTHER'S MAIDEN NAME <u>Virginia Parker Br. Fred. Md</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.			
				17. INFORMANT <u>Clearance Mackall</u> Address <u>" " "</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>754.1 Congenital Heart Defect</u> DUE TO (b) <u>(Patent Ductus &amp; others)</u> DUE TO (c) <u></u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>19</u> p. m. <u></u>				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>Aug</u> , 19 <u>58</u> , to <u>Dec 28</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>Dec 28</u> , 19 <u>58</u> , and that death occurred at <u>1:00 PM</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Page Jett</u> M.D.				ADDRESS (Street, city or town, state) DATE SIGNED			
PHYSICIAN'S NAME (Type) <u>PAUL C. JETT</u>				<u>Prince Frederick</u>			
22a. (BURIAL) CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
<u></u>		<u>12-29-58</u>		<u>PATUXENT</u>		<u>Huntington</u> <u>MD.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>P. E. Sewell</u> ADDRESS <u>Prince Frederick</u>				24a. REC'D BY REGISTRAR DATE <u>JAN 2 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kenna</u>	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1933

Page One of One

<p>1. Name of deceased: <u>JOHN J. MURPHY</u></p>		<p>2. Sex: <u>Male</u></p>	
<p>3. Date of birth: <u>1885</u></p>		<p>4. Place of birth: <u>NEW YORK</u></p>	
<p>5. Date of death: <u>1933</u></p>		<p>6. Place of death: <u>NEW YORK</u></p>	
<p>7. Cause of death: <u>Heart Disease</u></p>		<p>8. Duration of illness: <u>10 days</u></p>	
<p>9. Name of physician: <u>Dr. J. J. Murphy</u></p>		<p>10. Name of funeral home: <u>John J. Murphy</u></p>	
<p>11. Name of next of kin: <u>John J. Murphy</u></p>		<p>12. Name of informant: <u>John J. Murphy</u></p>	
<p>13. Name of registrar: <u>John J. Murphy</u></p>		<p>14. Name of official: <u>John J. Murphy</u></p>	
<p>15. Name of hospital: <u>John J. Murphy</u></p>		<p>16. Name of cemetery: <u>John J. Murphy</u></p>	
<p>17. Name of church: <u>John J. Murphy</u></p>		<p>18. Name of school: <u>John J. Murphy</u></p>	
<p>19. Name of employer: <u>John J. Murphy</u></p>		<p>20. Name of occupation: <u>John J. Murphy</u></p>	
<p>21. Name of residence: <u>John J. Murphy</u></p>		<p>22. Name of street: <u>John J. Murphy</u></p>	
<p>23. Name of city: <u>John J. Murphy</u></p>		<p>24. Name of state: <u>John J. Murphy</u></p>	
<p>25. Name of country: <u>John J. Murphy</u></p>		<p>26. Name of continent: <u>John J. Murphy</u></p>	
<p>27. Name of island: <u>John J. Murphy</u></p>		<p>28. Name of ocean: <u>John J. Murphy</u></p>	
<p>29. Name of mountain: <u>John J. Murphy</u></p>		<p>30. Name of river: <u>John J. Murphy</u></p>	
<p>31. Name of lake: <u>John J. Murphy</u></p>		<p>32. Name of sea: <u>John J. Murphy</u></p>	
<p>33. Name of bay: <u>John J. Murphy</u></p>		<p>34. Name of harbor: <u>John J. Murphy</u></p>	
<p>35. Name of strait: <u>John J. Murphy</u></p>		<p>36. Name of canal: <u>John J. Murphy</u></p>	
<p>37. Name of bridge: <u>John J. Murphy</u></p>		<p>38. Name of tunnel: <u>John J. Murphy</u></p>	
<p>39. Name of road: <u>John J. Murphy</u></p>		<p>40. Name of highway: <u>John J. Murphy</u></p>	
<p>41. Name of street: <u>John J. Murphy</u></p>		<p>42. Name of avenue: <u>John J. Murphy</u></p>	
<p>43. Name of boulevard: <u>John J. Murphy</u></p>		<p>44. Name of park: <u>John J. Murphy</u></p>	
<p>45. Name of square: <u>John J. Murphy</u></p>		<p>46. Name of plaza: <u>John J. Murphy</u></p>	
<p>47. Name of court: <u>John J. Murphy</u></p>		<p>48. Name of lane: <u>John J. Murphy</u></p>	
<p>49. Name of alley: <u>John J. Murphy</u></p>		<p>50. Name of drive: <u>John J. Murphy</u></p>	
<p>51. Name of way: <u>John J. Murphy</u></p>		<p>52. Name of path: <u>John J. Murphy</u></p>	
<p>53. Name of trail: <u>John J. Murphy</u></p>		<p>54. Name of route: <u>John J. Murphy</u></p>	
<p>55. Name of track: <u>John J. Murphy</u></p>		<p>56. Name of line: <u>John J. Murphy</u></p>	
<p>57. Name of road: <u>John J. Murphy</u></p>		<p>58. Name of highway: <u>John J. Murphy</u></p>	
<p>59. Name of street: <u>John J. Murphy</u></p>		<p>60. Name of avenue: <u>John J. Murphy</u></p>	
<p>61. Name of boulevard: <u>John J. Murphy</u></p>		<p>62. Name of park: <u>John J. Murphy</u></p>	
<p>63. Name of square: <u>John J. Murphy</u></p>		<p>64. Name of plaza: <u>John J. Murphy</u></p>	
<p>65. Name of court: <u>John J. Murphy</u></p>		<p>66. Name of lane: <u>John J. Murphy</u></p>	
<p>67. Name of alley: <u>John J. Murphy</u></p>		<p>68. Name of drive: <u>John J. Murphy</u></p>	
<p>69. Name of way: <u>John J. Murphy</u></p>		<p>70. Name of path: <u>John J. Murphy</u></p>	
<p>71. Name of trail: <u>John J. Murphy</u></p>		<p>72. Name of route: <u>John J. Murphy</u></p>	
<p>73. Name of track: <u>John J. Murphy</u></p>		<p>74. Name of line: <u>John J. Murphy</u></p>	
<p>75. Name of road: <u>John J. Murphy</u></p>		<p>76. Name of highway: <u>John J. Murphy</u></p>	
<p>77. Name of street: <u>John J. Murphy</u></p>		<p>78. Name of avenue: <u>John J. Murphy</u></p>	
<p>79. Name of boulevard: <u>John J. Murphy</u></p>		<p>80. Name of park: <u>John J. Murphy</u></p>	
<p>81. Name of square: <u>John J. Murphy</u></p>		<p>82. Name of plaza: <u>John J. Murphy</u></p>	
<p>83. Name of court: <u>John J. Murphy</u></p>		<p>84. Name of lane: <u>John J. Murphy</u></p>	
<p>85. Name of alley: <u>John J. Murphy</u></p>		<p>86. Name of drive: <u>John J. Murphy</u></p>	
<p>87. Name of way: <u>John J. Murphy</u></p>		<p>88. Name of path: <u>John J. Murphy</u></p>	
<p>89. Name of trail: <u>John J. Murphy</u></p>		<p>90. Name of route: <u>John J. Murphy</u></p>	
<p>91. Name of track: <u>John J. Murphy</u></p>		<p>92. Name of line: <u>John J. Murphy</u></p>	
<p>93. Name of road: <u>John J. Murphy</u></p>		<p>94. Name of highway: <u>John J. Murphy</u></p>	
<p>95. Name of street: <u>John J. Murphy</u></p>		<p>96. Name of avenue: <u>John J. Murphy</u></p>	
<p>97. Name of boulevard: <u>John J. Murphy</u></p>		<p>98. Name of park: <u>John J. Murphy</u></p>	
<p>99. Name of square: <u>John J. Murphy</u></p>		<p>100. Name of plaza: <u>John J. Murphy</u></p>	

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13533

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

13524

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Calvert</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <u>Md</u> b. COUNTY <u>Calvert</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>N. Beach</u>		c. LENGTH OF STAY IN 1b	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		d. STREET ADDRESS	
3. NAME OF DECEASED (Type or print) <u>Annie</u> First <u>Loretta</u> Middle <u>Maloney</u> Last		4. DATE OF DEATH Month <u>12</u> Day <u>5</u> Year <u>1958</u>	
5. SEX <u>7</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Nov. 25 1890</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>H W</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Md</u>	9. AGE (In years last birthday) <u>68</u> yrs.
11. BIRTH PLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>Edmund H. Laurin</u>		14. MOTHER'S MAIDEN NAME <u>Mary Dyer</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>Theresa Watake</u> Address <u>3588 Mary Co</u>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac failure</u> 322.2 DUE TO (b) <u>Alcohol toxicity</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, DUE TO (c)	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Found dead in home, had been dead 2 wks</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour <u>o. m.</u> <u>p. m.</u> <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <u>H W Ward</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type)		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>12-6-58</u>	22c. NAME OF CEMETERY OR CREMATORY <u>St. Lincoln</u>	22d. LOCATION (City, town, or county) (State) <u>Bladensburg Md</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Neel Funeral Home</u>		ADDRESS <u>4812 24 Ave NW</u>	
24a. REC'D BY REGISTRAR		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kneale</u>	
DATE <u>DEC 15 '58</u>			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. To FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.





13534 CERTIFICATE OF DEATH

Reg. Dist. No. 13525

1. PLACE OF DEATH o. COUNTY <u>Cabaret</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Ind</u> b. COUNTY <u>Cabaret</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Prince-Fredrick</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Prince-Fredrick</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Cabaret County Hospital</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Margaret</u> Middle <u>Peterson</u> Last <u>Martin</u>				4. DATE OF DEATH Month <u>Dec.</u> Day <u>27</u> Year <u>1958</u>			
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>July 30, 1870</u>	9. AGE (In years lost birthday) <u>88</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u>		11. BIRTHPLACE (State or foreign country) <u>Cabaret Co., Ind</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>Thomas B. Turner</u>				14. MOTHER'S MAIDEN NAME <u>Patty Dorsey</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service) <u>no</u>		16. SOCIAL SECURITY NO. <u>no</u>		17. INFORMANT <u>Dr. Thomas B. Turner - Baltimore, Ind.</u> Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>331X Pneumonia</u> DUE TO <u>Central Hemorrhage</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Chromosomal Abnormalities</u> DUE TO (c) <u>Chromosomal Abnormalities</u>						INTERVAL BETWEEN ONSET AND DEATH <u>17 days</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>Dec 10, 1958</u> to <u>Dec 27, 1958</u> , that I last saw the deceased alive on <u>Dec 27, 1958</u> , and that death occurred at <u>130</u> M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>R DeVilloriz</u> M.D.				ADDRESS (Street, city or town, state) <u>54 Remar</u> DATE SIGNED <u>12/27</u>			
PHYSICIAN'S NAME (Type) <u>R DeVilloriz</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Dec. 29, 1958</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Christ Church Cem</u>		22d. LOCATION (City, town, or county) (State) <u>Port Republic - Cabaret Co - Ind</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>A. A. Haskness &amp; Son - Mutual, Ind.</u> ADDRESS				24a. REC'D BY REGISTRAR <u>DATE DEC 30 '58</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

13584

## CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE 13

NAME OF DECEASED JAMES E. SMITH		DATE OF DEATH JAN 10 1917	
PLACE OF DEATH HOME		CITY BALTIMORE	
COUNTY BALTIMORE		STATE MARYLAND	
AGE 45		SEX MALE	
OCCUPATION CLOCK MAKER		EDUCATION HIGH SCHOOL	
MARRIED YES		SINGLE NO	
CAUSE OF DEATH HEART DISEASE		MANNER OF DEATH NATURAL	
PLACE OF BURIAL CATHOLIC CHURCH		DATE OF BURIAL JAN 12 1917	
NAME OF FUNERAL HOME JOHN J. SMITH		ADDRESS 1234 E. BALTIMORE	
NAME OF NEXT OF KIN JAMES E. SMITH		ADDRESS 1234 E. BALTIMORE	
NAME OF PHYSICIAN DR. J. E. SMITH		ADDRESS 1234 E. BALTIMORE	
NAME OF NURSE J. E. SMITH		ADDRESS 1234 E. BALTIMORE	
NAME OF MINISTER J. E. SMITH		ADDRESS 1234 E. BALTIMORE	
NAME OF CLERGYMAN J. E. SMITH		ADDRESS 1234 E. BALTIMORE	
NAME OF CHURCH CATHOLIC CHURCH		ADDRESS 1234 E. BALTIMORE	
NAME OF CEMETERY CATHOLIC CEMETERY		ADDRESS 1234 E. BALTIMORE	
NAME OF BURIAL J. E. SMITH		ADDRESS 1234 E. BALTIMORE	
NAME OF DECEASED JAMES E. SMITH		DATE OF DEATH JAN 10 1917	
PLACE OF DEATH HOME		CITY BALTIMORE	
COUNTY BALTIMORE		STATE MARYLAND	
AGE 45		SEX MALE	
OCCUPATION CLOCK MAKER		EDUCATION HIGH SCHOOL	
MARRIED YES		SINGLE NO	
CAUSE OF DEATH HEART DISEASE		MANNER OF DEATH NATURAL	
PLACE OF BURIAL CATHOLIC CHURCH		DATE OF BURIAL JAN 12 1917	
NAME OF FUNERAL HOME JOHN J. SMITH		ADDRESS 1234 E. BALTIMORE	
NAME OF NEXT OF KIN JAMES E. SMITH		ADDRESS 1234 E. BALTIMORE	
NAME OF PHYSICIAN DR. J. E. SMITH		ADDRESS 1234 E. BALTIMORE	
NAME OF NURSE J. E. SMITH		ADDRESS 1234 E. BALTIMORE	
NAME OF MINISTER J. E. SMITH		ADDRESS 1234 E. BALTIMORE	
NAME OF CLERGYMAN J. E. SMITH		ADDRESS 1234 E. BALTIMORE	
NAME OF CHURCH CATHOLIC CHURCH		ADDRESS 1234 E. BALTIMORE	
NAME OF CEMETERY CATHOLIC CEMETERY		ADDRESS 1234 E. BALTIMORE	
NAME OF BURIAL J. E. SMITH		ADDRESS 1234 E. BALTIMORE	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your file. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)  
5M 9/55

1  
13535 MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

13526

Items 3, 13, 14 Film G240 3-30-59 et

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Calvert</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If Institution, Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>Calvert</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Prince George's</u>		c. LENGTH OF STAY IN 1b <u>1</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Calvert Co. Hospital</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Everett</u> First <u>B</u> Middle <u>Merde</u> Last		4. DATE OF DEATH Month <u>12</u> Day <u>10</u> Year <u>1958</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>10/4/175</u>
9. AGE (In years last birthday) <u>83</u> yrs.		10. IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Farm</u>	
11. BIRTHPLACE (State or foreign country) <u>MD</u>		12. CITIZEN OF WHAT COUNTRY? <u>  </u>	
13. FATHER'S NAME <u>William H. Meade</u>		14. MOTHER'S MAIDEN NAME <u>Mary E. Craig</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or at present) <u>No</u>		16. SOCIAL SECURITY NO. <u>  </u>	
17. INFORMANT <u>Charbone Meade</u>		Address <u>Huntington MD</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>fractured leg</u> 904.0 DUE TO <u>Coronary artery disease</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>  </u> DUE TO (c) <u>  </u>		INTERVAL BETWEEN ONSET AND DEATH <u>18 days</u> <u>3 days</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Fell at home</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. <u>Fell at home</u>		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) <u>Fell at home</u>	
20c. TIME OF INJURY Month, Day, Year Hour o. m. <u>11/30</u> 19 <u>58</u> p. m. <u>  </u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Home</u>		20f. (City or town) <u>Huntington</u> (County) <u>Calvert</u> (State) <u>MD</u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <u>H. W. Ward</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>  </u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED <u>11/24/58</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Dec 12, 1958</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Maranda Cemetery</u>		22d. LOCATION (City, town, or county) <u>Huntington, Calvert Co. Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>A. A. Lockness &amp; Son - Mutual, Md.</u>		24. REC'D BY REGISTRAR DATE <u>JAN 28 '59</u>	
ADDRESS <u>  </u>		25. REGISTRAR'S SIGNATURE <u>  </u>	

Replacement: Film 238 - 1-28-59 ams

1

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

13527

13536

## CERTIFICATE OF DEATH

Reg. Dist. No. ....

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Calvert</u>		STATE <u>Maryland</u>		COUNTY <u>Calvert</u>			
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN <u>Prince Frederick</u>		<u>5</u>		TOWN <u>Broomes Island</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Calvert County Hospital</u>				STREET ADDRESS (If rural give location)			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH			
(First) <u>Charles</u> (Middle) <u>Parks</u> (Last)				(Month) <u>December</u> (Day) <u>20</u> (Year) <u>1958</u>			
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR		IF UNDER 24 HRS.
<u>Male</u>	<u>White</u>	<u>Married</u>	<u>8/29/82</u>	<u>76</u> yrs.	Months	Days	Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
<u>Waterman</u>		<u>Dyeing</u>		<u>Maryland</u>		<u>U.S.A.</u>	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
<u>William Parks</u>				<u>Annie Muir</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS			
<u>No</u>		<u>No</u>		<u>Mrs. Marie Williams</u> <u>Broomes Island</u>			
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
420.1 IMMEDIATE CAUSE (A)				<u>Cornary Arteriosclerosis</u>			
ANTECEDENT CAUSE(S) DUE TO				<u>Hypertension</u>			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE							
STATING UNDERLYING CAUSE LAST. DUE TO							
(C)							
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY?			
				YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> et work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>Dec 15</u> , 19 <u>58</u> , to <u>Dec 20</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>Dec 20</u> , 19 <u>58</u> , and that death occurred at <u>11:00</u> M., from the causes and on the date stated above.							
SIGNATURE <u>M. Williams</u>				DATE SIGNED <u>12/20/58</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY)				24. REC'D BY REGISTRAR			
<u>Burial</u>				<u>DEC 24 58</u>			
DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county)		(State)	
<u>Dec. 23, 1958</u>		<u>Broomes Island Cemetery</u>		<u>Broomes Island - Calvert Co - Md</u>			
25. FUNERAL DIRECTOR'S SIGNATURE				ADDRESS			
<u>G. A. Harkness &amp; Son - Mutual, Md</u>							

INSTRUCTIONS

1  
TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M



# CERTIFICATE OF DEATH

13380

Reg. No. 12

1. NAME OF DECEASED

2. SEX

3. AGE

4. DATE OF BIRTH

5. PLACE OF BIRTH

6. OCCUPATION

7. CAUSE OF DEATH

8. PLACE OF DEATH

9. TIME OF DEATH

10. SIGNATURE OF PHYSICIAN

11. SIGNATURE OF REGISTRAR

12. SIGNATURE OF WITNESS

13. SIGNATURE OF DECEASED

14. SIGNATURE OF NEXT OF KIN

15. SIGNATURE OF CLERK

16. SIGNATURE OF CHURCH CLERK

17. SIGNATURE OF MINISTERS

18. SIGNATURE OF OTHERS

19. SIGNATURE OF DECEASED

20. SIGNATURE OF NEXT OF KIN

21. SIGNATURE OF CLERK

22. SIGNATURE OF CHURCH CLERK

23. SIGNATURE OF MINISTERS

24. SIGNATURE OF OTHERS

25. SIGNATURE OF DECEASED

26. SIGNATURE OF NEXT OF KIN

27. SIGNATURE OF CLERK

28. SIGNATURE OF CHURCH CLERK

29. SIGNATURE OF MINISTERS

30. SIGNATURE OF OTHERS

31. SIGNATURE OF DECEASED

32. SIGNATURE OF NEXT OF KIN

33. SIGNATURE OF CLERK

34. SIGNATURE OF CHURCH CLERK

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216. SIGNATURE OF OTHERS

217. SIGNATURE OF DECEASED

218. SIGNATURE OF NEXT OF KIN

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221. SIGNATURE OF MINISTERS

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228. SIGNATURE OF OTHERS

229. SIGNATURE OF DECEASED

230. SIGNATURE OF NEXT OF KIN

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232. SIGNATURE OF CHURCH CLERK

233. SIGNATURE OF MINISTERS

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235. SIGNATURE OF DECEASED

236. SIGNATURE OF NEXT OF KIN

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238. SIGNATURE OF CHURCH CLERK

239. SIGNATURE OF MINISTERS

240. SIGNATURE OF OTHERS

241. SIGNATURE OF DECEASED

242. SIGNATURE OF NEXT OF KIN

243. SIGNATURE OF CLERK

244. SIGNATURE OF CHURCH CLERK

245. SIGNATURE OF MINISTERS

246. SIGNATURE OF OTHERS

247. SIGNATURE OF DECEASED

248. SIGNATURE OF NEXT OF KIN

249. SIGNATURE OF CLERK

250. SIGNATURE OF CHURCH CLERK



13537 CERTIFICATE OF DEATH

13528

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Calvert County</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Calvert County</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Prince Frederick</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Prince Frederick</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Calvert County Hospital</b>				e. STREET ADDRESS <b>—</b>		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Benjamin</b> Middle <b>T.</b> Last <b>Rawlings</b>				4. DATE OF DEATH Month <b>12</b> Day <b>6</b> Year <b>1958</b>			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>Dec. 1, 1867</b>	
9. AGE (In years last birthday) <b>91</b> yrs.		IF UNDER 1 YEAR Months <b>—</b> Days <b>—</b> Hours <b>—</b> Min. <b>—</b>		IF UNDER 24 HRS. Months <b>—</b> Days <b>—</b> Hours <b>—</b> Min. <b>—</b>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Farmer (Swine)</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Farming</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>	
12. CITIZEN OF WHAT COUNTRY? <b>United States</b>							
13. FATHER'S NAME <b>Fielder Rawlings</b>				14. MOTHER'S MAIDEN NAME <b>Elizabeth Bowen</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>—</b>		17. INFORMANT <b>Nelson Rawlings - Quantico, Va</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Uremia</b> <b>442X</b> DUE TO <b>Hypertensive C.V.R. disease</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>—</b> DUE TO (c) <b>—</b>						INTERVAL BETWEEN ONSET AND DEATH <b>21 days</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour <b>—</b> a. m. <b>—</b> p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>15 Oct</b> , 19 <b>58</b> , to <b>5 Dec</b> , 19 <b>58</b> , that I last saw the deceased alive on <b>5 Dec</b> , 19 <b>58</b> , and that death occurred at <b>6:30</b> A.M. from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>G. J. Weems</b>				ADDRESS (Street, city or town, state) <b>Huntingtown</b> DATE SIGNED <b>6 Dec 58</b>			
PHYSICIAN'S NAME (Type) <b>G. J. WEEMS</b>				M.D. <b>HUNTINGTOWN MD.</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>Dec. 8, 1958</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Ashbury Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Berster - Calvert Co., - Md</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>G. A. Harkness - Berster - Md</b>				24a. REC'D BY REGISTRAR <b>DEC 9 '58</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Hume</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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13538

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <u>Calvert</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Calvert</u> b. COUNTY <u>Calvert</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Prince Frederick</u>				c. LENGTH OF STAY IN 1b <u>3 mos. 28 days</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Calvert Co. Hospital</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>Clarence Oliver Stallings</u>				4. DATE OF DEATH Month <u>12</u> Day <u>30</u> Year <u>1958</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Mar. 22, 1899</u>	9. AGE (In years last birthday) <u>59</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Janitor</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Farmer</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland U.S.A.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Clarence Stallings</u>				14. MOTHER'S MAIDEN NAME <u>Bessie Stallings</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u> (If yes, give year or dates of service) <u>World War II</u>		16. SOCIAL SECURITY NO. <u>218-14-3553M</u>		17. INFORMANT <u>Emily Dean Stallings</u> Address <u>Med</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Anemia</u> <u>443X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Hypertension c.v.d.</u> (c) <u>Cerebral thrombosis</u>						INTERVAL BETWEEN ONSET AND DEATH <u>4 weeks</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Sept 2, 1958</u> , to <u>Dec 30, 1958</u> , that I last saw the deceased alive on <u>Dec 30, 1958</u> , and that death occurred at <u>12:12</u> M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>R. de Villanueva</u> M.D.				ADDRESS (Street, city or town, state) <u>St. Bernard</u>		DATE SIGNED <u>12/30/58</u>	
PHYSICIAN'S NAME (Type) <u>R. de VILLARREAL</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Jan. 1, 1959</u>		22c. NAME OF CEMETERY OR CRYPTORY <u>St. Harmony</u>		22d. LOCATION (City, town, or county) (State) <u>St. Bernard Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Hutchins Funeral Home, Owings Md.</u> ADDRESS				24a. REC'D BY REGISTRAR DATE <u>JAN 5 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# CERTIFICATE OF DEATH

1. NAME OF DECEASED		2. SEX		3. AGE		4. DATE OF BIRTH		5. PLACE OF BIRTH	
6. OCCUPATION		7. MARITAL STATUS		8. RACE		9. RELIGION		10. EDUCATION	
11. DATE OF DEATH		12. TIME OF DEATH		13. PLACE OF DEATH		14. CAUSE OF DEATH		15. MANNER OF DEATH	
16. SIGNATURE OF DECEASED		17. SIGNATURE OF WITNESS		18. SIGNATURE OF PHYSICIAN		19. SIGNATURE OF MINISTER		20. SIGNATURE OF CORONER	
21. SIGNATURE OF DECEASED		22. SIGNATURE OF WITNESS		23. SIGNATURE OF PHYSICIAN		24. SIGNATURE OF MINISTER		25. SIGNATURE OF CORONER	
26. SIGNATURE OF DECEASED		27. SIGNATURE OF WITNESS		28. SIGNATURE OF PHYSICIAN		29. SIGNATURE OF MINISTER		30. SIGNATURE OF CORONER	
31. SIGNATURE OF DECEASED		32. SIGNATURE OF WITNESS		33. SIGNATURE OF PHYSICIAN		34. SIGNATURE OF MINISTER		35. SIGNATURE OF CORONER	
36. SIGNATURE OF DECEASED		37. SIGNATURE OF WITNESS		38. SIGNATURE OF PHYSICIAN		39. SIGNATURE OF MINISTER		40. SIGNATURE OF CORONER	
41. SIGNATURE OF DECEASED		42. SIGNATURE OF WITNESS		43. SIGNATURE OF PHYSICIAN		44. SIGNATURE OF MINISTER		45. SIGNATURE OF CORONER	
46. SIGNATURE OF DECEASED		47. SIGNATURE OF WITNESS		48. SIGNATURE OF PHYSICIAN		49. SIGNATURE OF MINISTER		50. SIGNATURE OF CORONER	
51. SIGNATURE OF DECEASED		52. SIGNATURE OF WITNESS		53. SIGNATURE OF PHYSICIAN		54. SIGNATURE OF MINISTER		55. SIGNATURE OF CORONER	
56. SIGNATURE OF DECEASED		57. SIGNATURE OF WITNESS		58. SIGNATURE OF PHYSICIAN		59. SIGNATURE OF MINISTER		60. SIGNATURE OF CORONER	
61. SIGNATURE OF DECEASED		62. SIGNATURE OF WITNESS		63. SIGNATURE OF PHYSICIAN		64. SIGNATURE OF MINISTER		65. SIGNATURE OF CORONER	
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81. SIGNATURE OF DECEASED		82. SIGNATURE OF WITNESS		83. SIGNATURE OF PHYSICIAN		84. SIGNATURE OF MINISTER		85. SIGNATURE OF CORONER	
86. SIGNATURE OF DECEASED		87. SIGNATURE OF WITNESS		88. SIGNATURE OF PHYSICIAN		89. SIGNATURE OF MINISTER		90. SIGNATURE OF CORONER	
91. SIGNATURE OF DECEASED		92. SIGNATURE OF WITNESS		93. SIGNATURE OF PHYSICIAN		94. SIGNATURE OF MINISTER		95. SIGNATURE OF CORONER	
96. SIGNATURE OF DECEASED		97. SIGNATURE OF WITNESS		98. SIGNATURE OF PHYSICIAN		99. SIGNATURE OF MINISTER		100. SIGNATURE OF CORONER	

THIS CERTIFICATE IS TO BE FILED IN THE OFFICE OF THE CLERK OF THE COURT, IN THE COUNTY OF [ ] STATE OF [ ]

IN WITNESS WHEREOF, I have hereunto set my hand and the seal of said office, this [ ] day of [ ] A.D. 19[ ]

CLERK OF THE COURT

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)  
15M 9/55

135339 Item 1 Film G237 1-5-59 et  
STATE OF MARYLAND—BALTIMORE, 18  
CERTIFICATE OF DEATH

135330

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Calvert</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md</u> b. COUNTY <u>Charles</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Prince Frederick 4 Mo</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Indian Head Md</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Calvert Co. Nursing Home</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Fannie</u> First <u>Swan</u> Middle <u>Swan</u> Last <u>Swan</u>		4. DATE OF DEATH Month <u>12</u> Day <u>20</u> Year <u>1938</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>1871</u> <u>87</u> yrs.
9. AGE (In years last birthday) <u>67</u> yrs.		10. IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>H W</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>George Zakory Davis</u>		14. MOTHER'S MAIDEN NAME <u>Mary 3</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>—</u>	
17. INFORMANT <u>Mrs. Howard F. Swan</u> Address <u>Indian Head, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral hemorrhage</u> DUE TO <u>331X</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>  </u> DUE TO (c) <u>  </u>		INTERVAL BETWEEN ONSET AND DEATH <u>4 hrs</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Felt badly at work gradually and had tired</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour <u>  </u> <u>  </u> a.m. <u>19</u> p. m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>12/19</u> to <u>12/20</u> , 19 <u>38</u> , that I last saw the deceased alive on <u>12/19</u> , 19 <u>38</u> , and that death occurred at <u>3:30 P.</u> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>H W Wand</u> M.D.		ADDRESS (Street, city or town, state) <u>  </u> DATE SIGNED <u>12/21/38</u>	
PHYSICIAN'S NAME (Type) <u>  </u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>12/24/38</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Trinity</u>	22d. LOCATION (City, town, or county) (State) <u>Newport, Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>The Hunt &amp; Funeral Home, Waldorf, Md.</u> ADDRESS <u>  </u>		24a. REC'D BY REGISTRAR DATE <u>DEC 29 '38</u>	24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>



